SC DHEC DIVISION - IN-SERVICE TRAINING PROGRAM
EMT-PARAMEDIC RE-CERTIFICATION REQUEST

SC EMT-Paramedic Certification Number: _____ Expiration Date_____

Last Name: _____ First Name: _____ Middle Initial: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number + Area Code: _____ E-Mail: _____

_____ Yes _____ No *Since your last re-certification, have you been convicted of a felony?* If **yes,** you must provide official documentation that fully describes the offence, current status and disposition of the case.

SC Licensed EMS Provider whose IST program you are affiliated with: _____

SECTION I: ***Didactic Requirements***

Date Completed	Divisions	Hours Required	Hours Earned
	Preparatory	6	
	Airway Management & Vent.	6	
	Patient Assessment	0	
	Trauma	10	
	Medical	18	
	Special Considerations	6	
	Operations	2	
	Total Hours	**48**	

SECTION II: ***Skill Verification*** *Competency verified by Training Officer (T.O.) -or- Medical Control Physician (M.D.)*

Skills	Verified by T.O.	Verified by M.D,
Patient Assessment / Management *(Medical & Trauma)*		
Ventilatory Management Skills / Knowledge *(Simple Adjuncts, Supplemental Oxygen, BVM one & two rescuer, LMA, Oral Suction, Intubation, Dual Lumen, Chest Decompression, Sterile Suction)*		
Cardiac Arrest Management *(Adult CPR one & two rescuer, Child CPR, Infant CPR, Adult, Child & Infant Obstructed Airway, AED, ECG Monitoring & Rhythm Identification 3-Lead & 12-Lead, External Pacing, Vagal Maneuvers)*		
Hemorrhage Control & Splinting Procedures *(Direct Pressure, Pressure Point, Tourniquet, PASG, Upper & Lower Extremities)*		
Spinal Immobilization *(Seated & Lying Patients)*		

Skills	Verified by T.O.	Verified by M.D,
OB / Gynecologic Skills / Knowledge		
Other Related Skills / Knowledge *(BGL Monitoring, Assisted Meds, Administered Meds IV & IO, IM, Sub-Q, Drips ET, Rectal, Inter-Facility, RSI, Patient Lifting/Stretcher Handling, Radio Communications, Report Writing & Documentation)*		

SECTION III: ***Attendance Requirements*** List the **Month** & **Year** each time this individual attended an IST class.

EMT Certification Year One From_____ To _____	**EMT Certification Year Two From_____ To _____**	**EMT Certification Year Three From_____ To _____**

SECTION IV: ***BLS & ACLS Credentials*** Place a **copy** of the individual's BLS & ACLS **cards** in the appropriate block. **A copy of the cards or rosters are required!**

BLS Credential Here	ACLS Credential Here
Must be ONE of the following: *(Provider or Instructor)* Amer Heart Assoc (AHA) BLS for the Health Care Professional American Red Cross (ARC) CPR for the Professional Rescuer American Safety & Health Institute (ASHI) CPR Pro *May submit copy of official AHA, ARC or ASHI course roster in lieu of card.*	Must be ONE of the following: *(Provider or Instructor)* American Heart Association (AHA) ACLS American Safety & Health Institute (ASHI) ACLS *May submit copy of official AHA or ASHI course roster in lieu of card.*

SECTION V: ATTACH A COMPLETED & SIGNED *CERTIFICATE APPLICATION* (Blue) **CARD**

Didactic, Attendance & Skills Verifications:
I verify that the above EMT-Paramedic has satisfied all didactic, attendance & skills requirements during the period of his/her SC EMT certification. Official documentation in the form of ***signed*** *class attendance rosters & skill verification sheets along with a completed ans signed IST Re-certification Packet, are maintained as verification. I understand that any falsification of these records*

may be sufficient cause for SC DHEC Division of EMS to remove the certification of this individual as well as take disciplinary action, up to and including, cancellation of this SC licensed EMS Provider's IST Program and, revocation of the IST Training Officer's EMT certification. I understand that SC DHEC Division of EMS may request an audit of these records at any time.

_____ _____

Signature / Date ***IST Training Officer*** *Signature / Date* ***Medical Control Physician***

I affirm that ALL statements on this form are true to the best of my knowledge and that any incorrect or false information may be sufficient cause for SC DHEC Division of EMS to revoke my certification.

_____

Signature / Date ***EMT-Paramedic Re-Certification Candidate***